Pediatric Cardiology of Austin

Tell Us About Your Child...

First Name _____ Middle Initial _____ Last Name _____ Male ____ Female ____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Social Security # _____

Race/Ethnicity **(Circle One):** Caucasian/White Asian Black/ African American Hispanic/Latino American Indian/Alaska Native Hawaiian/Other Pacific Islander Other

Pediatrician/Primary Care _____ Phone Number _____

Referring Physician (if different) _____ Phone Number _____

Pharmacy Name/Location _____ Phone Number _____

Tell Us About Mom...

Name _____

Email _____

Mailing Address _____

City _____ State _____ Zip _____

Employer _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ extension _____

Social Security _____ Date of Birth _____

Tell Us About Dad...

Name _____

Email _____

Mailing Address _____

City _____ State _____ Zip _____

Employer _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ extension _____

Social Security _____ Date of Birth _____

Please provide us with EACH insurance card, so that we may obtain additional information for claim filing.

Primary Insurance

Is your child covered by any other insurance? Yes ____ No____

Insurance Company _____

Name of Policy Holder _____

Policy Holder's Social Security# _____

Secondary Insurance Company _____

Name of Policy Holder _____

Policy Holder's Social Security# _____

Policy Holder's Date of Birth _____ Policy Holder's Date of Birth _____

Relationship to Patient _____ Relationship to Patient _____

Policy Holder's Employer _____ Policy Holder's Employer _____
Is Policy Through Employer? Yes _____ No _____ Is Policy Through Employer? Yes _____ No _____

In Case Of Emergency, please provide us with a name and phone # of another person **(not listed above)** that we may contact.

Name _____ Relationship _____ Phone # _____

Medical Care: I authorize the physicians of Pediatric Cardiology of Austin to provide my child with reasonable and proper medical care.
Assignment of Benefits: I hereby assign, transfer, and set over to Pediatric Cardiology of Austin all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. **I agree that I am financially responsible for any unpaid deductible and/or copayments that are due at the time services are rendered. I understand that as a courtesy, all charges will be filed with my primary and secondary insurances. Charges not payable or non-covered by my insurance are my responsibility. If I am a PPO or HMO participant, I understand that I am responsible for obtaining any necessary referrals and/or authorizations prior to the appointment. This authorization shall remain valid until written notice is given by me revoking said authorization.**

_____ _____ _____

Signature **Date** **Relationship to Patient**